Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST
P O BOX 890008
HOUSTON TX 77289

Carrier's Austin Representative Box
Box Number 15

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Date Received
January 23, 2012

MFDR Tracking Number
M4-12-1708-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On December 13, 2011, HealthTrust sent a in formal request for reconsideration to the carrier. The carrier returned all claims unpaid and this time they had one single reason for denial---extent of injury. Upon discussions with the adjustor on file, the adjustor forwarded a copy of a CCH Decision that was reached on June 28, 2011, prior to HealthTrust seeking preauthorization for their services. The conclusion was that the carrier admitted that there were 4 compensable body parts: 1) Lumbar sprain/strain; 2) Contusion of both legs; 3) Contusion to the lower posterior right back; 4) Contusion of the chest…The CCH ruled that the diagnosis codes used by HealthTrust were compensable. HealthTrust utilized the accepted diagnosis codes in the preauthorization request and received complete authorization for these services. Now the carrier still wants to deny claims because they do not 'feel' that they are related…"

Amount in Dispute: $26,667.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier maintains its denial for services provided…"

Response Submitted by: Ace/ESIS WC, P. O. Box 6563, Scranton, PA 18505

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2011	90806	$147.56	$141.04
October 18, 2011	97799-CP x 8 hours	$1,560.00	$800.00
October 20, 2011	97799-CP x 8 hours	$1,560.00	$800.00
October 21, 2011	97799-CP x 8 hours	$1,560.00	$800.00
October 24, 2011	97799-CP x 8 hours	$1,560.00	$800.00
October 25, 2011	97799-CP x 8 hours	$1,560.00	$800.00
October 26, 2011	97799-CP x 8 hours	$1,560.00	$800.00
October 27, 2011	97799-CP x 8 hours	$1,560.00	$800.00
November 15, 2011	97799-CP x 8 hours	$1,560.00	$800.00
November 16, 2011	97799-CP x 8 hours	$1,560.00	$800.00
November 17, 2011	97799-CP x 8 hours	$1,560.00	$800.00
November 18, 2011	97799-CP x 8 hours	$1,560.00	$800.00
November 21, 2011	97799-CP x 8 hours	$1,560.00	$800.00

November 22, 2011 November 23, 2011 November 28, 2011 November 29, 2011 November 30, 2011	97799-CP x 8 hours 97799-CP x 8 hours 97799-CP x 8 hours 97799-CP x 8 hours 97799-CP x 8 hours	$1,560.00 $1,560.00 $1,560.00 $1,560.00 $1,560.00	$800.00 $800.00 $800.00 $800.00 $800.00
TOTAL		$26,667.56	$13,741.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.204 sets out medical fee guidelines for workers' compensation specific services provided on or after March 1, 2008.
4. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 26, 2011
   - 1 – (167) – This (these) diagnosis (es) is (are) not covered.
   - 1 – The service or diagnosis is not related to the covered injury or body part. (XB52)

   Explanation of benefits dated November 4, 2011
   - 1 – (B13) – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 1 – B13 – Previously paid. Payment for this claim or service may have been provided in a previous payment. (XB33)

   Explanation of benefits dated November 16, 2011
   - 1 – (B13) – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 1 – B13 – Previously paid. Payment for this claim or service may have been provided in a previous payment. (XB33)

   Explanation of benefits dated November 28, 2011
   - 1 – (125) – Submission/billing error (s).
   - 1 – Provider's State License Number is Invalid or was not received. (X282)

   Explanation of benefits dated December 5, 2011
   - 1 – (219) – Based on extent of injury.
   - 1 – 219 – Based on extent of injury. (XB20)

   Explanation of benefits dated December 7, 2011
   - 1 – (219) – Based on extent of injury.
   - 1 – 219 – Based on extent of injury. (XB20)

   Explanation of benefits dated December 9, 2011
   - 1 – (219) – Based on extent of injury.
   - 1 – 219 – Based on extent of injury. (XB20)

   Explanation of benefits dated December 14, 2011
   - 1 – (219) – Based on extent of injury.
   - 1 – 219 – Based on extent of injury. (XB20)

   Explanation of benefits dated December 15, 2011
   - 1 – (219) – Based on extent of injury.
   - 1 – 219 – Based on extent of injury. (XB20)

Explanation of benefits dated December 21, 2011
- (219) – Based on extent of injury.
- 219 – Based on extent of injury. (XB20)

Explanation of benefits dated December 28, 2011
- (219) – Based on extent of injury.
- 219 – Based on extent of injury. (XB20)

Explanation of benefits dated December 29, 2011
- (219) – Based on extent of injury.
- 219 – Based on extent of injury. (XB20)

Explanation of benefits dated January 12, 2012
- (219) – Based on extent of injury.
- 219 – Based on extent of injury. (XB20)
- 18 – Duplicate claim/service.

Issues

1. Has the extent of injury issue been resolved?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Is the requestor the requestor entitled to reimbursement for Psychotherapy treatment?
4. Is the requestor the requestor entitled to reimbursement for the Chronic Pain Management Program?

Findings

1. A Benefit Review Conference was held on May 4, 2011 to mediate resolution of the disputed issue however, the parties were unable to reach an agreement. A Contested Case Hearing was held on June 22, 2011 that found that the injured employee's compensable injury of July 9, 2010 does not extend to and include lumbar MRI findings dated July 21, 2010 (1. Lmbar spondylosis as described. Disc desiccation. 2. L3-4 broad based bulge. Minimal central canal stenosis. No neural foraminal stenosis. 3. L4-5 large broad based disc bulge. Enlarged canal and no neural foramen stenosis is appreciated. 4. L5-S1 large broad based disc with disc material encroaching into the neural foramen bilaterally. No significant central canal stenosis. There is moderate to severe neural foramen stenosis bilaterally impinging on the exiting nerve roots.). The provider billed with the following ICD-9 codes on the CMS 1500 forms: 847.2 (Lumbar sprain/strain); 722.10 (Displacement lumbar intervert disc); 844.2 (Sprain/strain of cruciate ligament); and 847.1 (Thoracic sprain/strain). The Division has determined that the extent of injury issue has been resolved, and the disputed services will be reviewed per the applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." 28 Texas Administrative Code §134.600(p)(7) requires preauthorization of "all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program." Review of the submitted preauthorization letter dated August 24, 2011 supports Individual Psychotherapy Sessions x 6 were approved under authorization number 99869 with a start date of August 22, 2011 and an end date of October 21, 2011; preauthorization letter dated October 13, 2011 supports the Chronic Pain Management Program was approved for 80 hours under authorization number 103950 with a start date of October 10, 2011 and an end date of December 9, 2011; and preauthorization letter dated November 20, 2011 supports the Chronic Pain Management program was approved for an additional 80 hours under authorization number 105846 with a start date of November 1, 2011 and an end date of December 31, 2011 which includes the disputed services.
3. The requestor has supported their position that the disputed psychotherapy services were preauthorized per 28 Texas Administrative Code §134.600; therefore, the requestor is entitled to reimbursement as follows per 28 Texas Administrative Code §134.203. 28 Texas Administrative Code §134.203(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply…(a) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." 28 Texas Administrative Code §134.203(c) states, in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." For service categories of Evaluation Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting provided in 2011, the conversation factor to be applied is $54.54. The MAR for

CPT code 90806 is as follows: DWC conversion factor of $54.54 divided by Medicare conversion factor of 33.9764 = $1.605 X Participating amount of $87.86 = $141.04. This amount is recommended.

4. The requestor has supported their position that the disputed chronic pain management program was preauthorized per 28 Texas Administrative Code §134.600; therefore, the requestor is entitled to reimbursement per 28 Texas Administrative Code §134.204(h)(5)(B), states "Reimbursement shall be $125.00 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." Review of the submitted documentation finds that based on the factual determination that the provider billed the disputed services without the –CA modifier, reimbursement will be 80% of the CARF maximum allowable reimbursement (MAR).

DOS October 18, 2011: $100.00 x 8 hours = $800.00
DOS October 20, 2011: $100.00 x 8 hours = $800.00
DOS October 21, 2011: $100.00 x 8 hours = $800.00
DOS October 24, 2011: $100.00 x 8 hours = $800.00
DOS October 25, 2011: $100.00 x 8 hours = $800.00
DOS October 26, 2011: $100.00 x 8 hours = $800.00
DOS October 27, 2011: $100.00 x 8 hours = $800.00
DOS November 15, 2011: $100.00 x 8 hours = $800.00
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DOS November 23, 2011: $100.00 x 8 hours = $800.00
DOS November 28, 2011: $100.00 x 8 hours = $800.00
DOS November 29, 2011: $100.00 x 8 hours = $800.00
DOS November 30, 2011: $100.00 x 8 hours = $800.00

TOTAL DUE: $13,741.04

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $13,741.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $13,741.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 29, 2012 Date
Signature	Medical Fee Dispute Resolution Manager	June 29, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.